San Bernardino County In-Home Supportive Services Public Authority

686 E. Mill St, San Bernardino, CA 92415-0034
(909) 386-5014 • Toll Free 1 (866) 985-6322 • Fax (909) 891-9130

CLIENT REQUEST FOR REGISTRY SERVICES

NAME:_____
Last Name First Name MI

ADDRESS: _____, CA _____
Street City Zip Code

SS#: _____-____-_____ **PHONE:** (_____) _____ **E-mail**_____

IHSS SOCIAL WORKER'S NAME: _____**Phone #**_____

1. **My Primary language is:** ☐ **English** ☐ **Spanish** **Other:**_____
2. **Do you smoke?** ☐ **Yes** ☐ **No**
3. **Do you have pets in your home?** ☐ **Yes** ☐ **No**
4. **Do you need a Provider experienced in any of the following?**
   ☐ **Mental Disability** **Type** _____
   ☐ **Terminal Illness** **Type** _____
   ☐ **Infectious Disease** **Type** _____
   ☐ **Developmentally Disabled** **Type** _____
5. **Do you have any health conditions?** ☐ **Yes** ☐ **No** ☐ **If yes, please list:** _____
   _____ _____
6. **Would you hire a Provider with a criminal background history?** ☐ **Yes** ☐ **No**
7. **Do you have a car?** ☐ **Yes** ☐ **No** ☐ **Provider must have car**
8. **Will you allow a Provider to drive your car?** ☐ **Yes** ☐ **No**
9. **Is your home near public transportation?** ☐ **Yes** ☐ **No**
10. **Do you live alone?** ☐ **Yes** ☐ **No** ☐ **If no, please state:**_____
11. **Provider gender preference** ☐ **Male** ☐ **Female** ☐ **No Preference**
12. **Will you hire a Provider that is a smoker?** ☐ **Yes** ☐ **No** ☐ **Preference / under what condition:** _____
13. **How do you move throughout your home?**

☐ **Ambulate (walk)** ☐ **Bed bound** ☐ **Use a cane** ☐ **Use a walker** ☐ **Use a wheelchair**

14. **Do you currently have a provider?**

☐ **On a temporary basis from** _____ **to** _____ ☐ **I need a permanent Provider**

☐ **2nd Provider**

15. **What are your schedule preferences regarding a Provider? (please check all that apply):**

☐ **Morning** ☐ **Afternoons** ☐ **Evenings** ☐ **Overnights**

☐ **Monday – Friday (Daily)** ☐ **Monday – Friday (1 – 4 days a week)** ☐ **Weekends**

AUTHORIZATION FOR RELEASE OF INFORMATION

Terms of Use and Release of Information

I understand that the information contained on this application is intended for the exclusive use of the San Bernardino County In-Home Supportive Services Public Authority (Public Authority) for the purpose of providing me a list of referrals of pre-screened IHSS Providers. I understand that my use of Registry Services does not commit me to hiring any individual referred by the Public Authority, nor does it imply a guarantee of satisfaction with the persons referred. I understand that I retain the right to hire, fire and supervise the work of any IHSS Provider referred to me by the Public Authority.

Terms of Personal Release of Information

In order for the Public Authority to obtain from or release to other parties any information about you, Federal and State laws require your specific authorization. Please check all applicable sections below.

I hereby authorize the Public Authority to exchange with:

☐ **IHSS / DAAS** ☐ **Provider** ☐ **Hospital** ☐ **Emergency / Contact**

☐ **Other: _____**

If you have authorized to discuss confidential information, specify the period during which we may communicate with the person's / agencies listed above, by checking the appropriate box below.

☐ **I authorize ongoing communication unless I revoke this consent in writing**

☐ **I authorize communication only until _____ (specify date).**

I understand that I do not have to agree to release confidential information and that I may withdraw this consent at any time in writing, but if I do, it will not have any effect on any actions IHSS Public Authority took before it received the revocation. A facsimile of this form will be regarded as valid as the original.

_____ _____

Client Signature **Date**

_____

Name (printed)

EMERGENCY CONTACT:

NAME	PHONE NUMBER	RELATIONSHIP TO YOU

ASSISTANCE IN COMPLETEING THIS APPLICATION WAS PROVIDED BY:

_____ _____ _____

Name Signature Date